



Relationship between Psychosocial Care Centers and Services in Primary Health Care*

Articulação entre Centros de Atenção Psicossocial e Serviços de Atenção Básica de Saúde

Articulación entre Centros de Atención Psicosocial y Servicios de Atención Básica de Salud

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ABSTRACT

Objective: To analyze forms of articulation that the Centers for Psychosocial Care (CAPS) established with the Primary Health Care Services. **Methods:** A descriptive, qualitative study conducted using document review of 23 Therapeutic Projects of the CAPS type I and II, of 23 cities in the southern region of Brazil (PR, SC and RS). **Results:** It was observed that the structure of articulation occurs basically through the supervision and training of teams, and a reference and counter-reference system, often masked under the logic of the referrals. However, these actions are more suggestive, referred to in documents as objectives, than they are properly translated into actions and concrete operational logic of those in daily practice services. **Conclusion:** In fact, attention to the complexity of the demand for mental health is dependent on a gradual construction of joint responsibility guided by the various services that comprise the network of care.

Keywords: Health care reform; Mental health services; Primary health care; Public policies; Unified Health System

RESUMO

Objetivo: Analisar as formas de articulação que os Centros de Atenção Psicossocial (CAPS) estabelecem com os Serviços de Atenção Básica de Saúde. **Métodos:** Estudo descritivo de abordagem qualitativa realizado por meio de análise documental de 23 Projetos Terapêuticos dos CAPS tipo I e II de 23 cidades da Região Sul do Brasil (PR, SC e RS). **Resultados:** Pôde-se observar que esta articulação estrutura-se basicamente na supervisão e capacitação das equipes e em um sistema de referência e contrarreferência, muitas vezes, mascarados sob a lógica dos encaminhamentos. No entanto, estas ações encontram-se mais sugestivas, referidas nos documentos como objetivos, do que propriamente traduzidas em ações como lógica de operacionalização concreta destas, na prática cotidiana dos serviços. **Conclusão:** De fato, a atenção à complexidade da demanda em saúde mental é dependente de uma construção gradativa de articulações orientadas pela corresponsabilização dos diferentes serviços que compõem a rede de atenção.

Descritores: Reforma dos serviços de saúde; Serviços de saúde mental; Atenção primária à saúde; Políticas públicas; Sistema Único de Saúde

RESUMEN

Objetivo: Analizar las formas de articulación que los Centros de Atención Psicosocial (CAPS) establecen con los Servicios de Atención Básica de Salud. **Métodos:** Estudio descriptivo de abordaje cualitativo realizado por medio de análisis documental de 23 Proyectos Terapêuticos de los CAPS tipo I y II de 23 ciudades de la Región Sur del Brasil (PR, SC y RS). **Resultados:** Se puede observar que esta articulación se estructura básicamente en la supervisión y capacitación de los equipos y en un sistema de referencia y contrarreferencia, muchas veces, enmascarados bajo la lógica de los encaminhamientos. Entre tanto, estas acciones se encuentran más sugestivas, referidas en los documentos como objetivos, de lo que propriamente traducidas en acciones como lógica de operacionalización concreta de éstas, en la práctica cotidiana de los servicios. **Conclusión:** De hecho, la atención a la complejidad de la demanda en salud mental depende de una construcción gradual de articulaciones orientadas por la corresponsabilización de los diferentes servicios que componen la red de atención.

Descriptores: Reforma de la atención de salud; Servicios de salud mental; Atención primaria de salud; Políticas Públicas; Sistema Único de Salud

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INTRODUCTION

This study was driven by assumptions of the psychiatric care restructuring within Brazil - the Brazilian Psychiatric Reform - a continuous process of building reflections and transformations that occurs simultaneously in the caring, cultural, and conceptual fields. In this context, the objective is to change the relationship that society, individuals and institutions establish with mental illness, leading them in order to overcome the stigma of insanity, to establish an integrated connection with coexistence, exchange, solidarity, positivity and care ⁽¹⁾.

Gradually, structured measures for a national public policy in setting guidelines of a reformist nature will be linked to important achievements, with the implementation of successful innovative experiences in all Brazilian regions, the redirection of finances for mental health interventions, prioritization of alternatives to hospitalization, and formalization of stricter rules for the operation of public psychiatric hospitals or contracted services ⁽²⁾.

Amid these conceptual, cultural and welfare changes that lead to the deployment of alternative devices, the Center for Psychosocial Care (CAPS) is regarded as a strategic service, articulating and organizing a network of attention focused on multiple authorities within a territory that includes primary care. Because CAPS had the implementation of its services legalized in 2001 ⁽³⁾, it is worth analyzing the forms of articulation and externalization of its practices enabling it to move outside its structural spaces to serve the territory, a space that includes the health services, individuals and their social networks, and solidarity.

These devices were thought of as a structure aligned to the guiding principles of other health services linked to the *Sistema Único de Saúde* (National Health System, or SUS). To this end, they should work to recover the capabilities of the surrounding territory, such as its own publicly managed institution, seek to ensure access, integrity and resoluteness in attention, and to welcome customers with severe mental illness, and their families, through the work of a multiprofessional team ⁽⁴⁾.

According to the recommendations of the Ministry of Health, the consolidation of psychiatric reform depends basically on the construction of a network of community care; in other words, different services linked to each other, replacing psychiatric hospitals, so as to form a referral system with the capacity to absorb and accommodate individuals in psychological distress.

At this time, networks of care as a means of communicating activities and services that transform and reinvent roles and territories, are fundamental for the establishment and operation of different forms of care. This network articulation breaks with the concept of the centrality of care, such as through offering dynamism

and flexibility of services, in order to generate better outcomes of care.

However, this is not only a Brazilian demand. When we think of Latin America, there are cited necessities for further support of care delivery, including: training and research through intersectoral collaboration and initiatives; integration of mental health and primary care services; an increased, multidisciplinary mental health workforce; equitable geographic distribution of that workforce; and, the addition of more effective public policies ⁽⁵⁾.

We know that every health care service, whether it is considered to be mental health or not, has characteristics of organization and involvement with the community to which it belongs, in accordance with the commitment of local management of the care network and its users.

Within this context, this study sought to identify, through document analysis of the Therapeutic Project of the CAPS, planned actions that aimed to bring together and articulate the CAPS services of primary health care. It is understood that these services were responsible for ordering movements of, and approaches within, the social environment of the subjects, promoting dynamism and flexibility, and generating new results for attention to individuals with mental disorders.

METHODS

This was a qualitative, descriptive and analytical study. It was configured based on data previously collected in the research project, *Evaluation of CAPS in Southern Brazil* (CAPSUL)⁽⁶⁾, conducted during the period of January 2006 to February 2008. For this purpose, we included 30 municipalities from the state of Paraná, nine in the state of Santa Catarina, and finally, 18 in the state of Rio Grande do Sul. The municipalities were randomly selected, using as a criterion the proportion of services by state and interstate region, and the type of CAPS, with 50% for all the CAPS I and 50% for the CAPS II, totaling 30 services. Of the group of 30 CAPS services studied, seven did not have Therapeutic Services Projects (TSP) or they were not provided to the interviewers, so 23 documents were analyzed for this study.

After approval was received from the Committee on Ethics in Research of the Faculty of Medicine, Federal University of Pelotas (Of. 074/05 on November 11, 2005), we began to collect data. The coordinators of CAPS were the subjects to whom the interviewers provided copies of the TSPs and, thus, those individuals who agreed to participate in the study signed the Terms of Free and Informed Consent.

For data analysis, a qualitative technique was used for analysis of documents of the CAPS TSPs, to better understand the interventions envisaged in the documents

that supported the practice of mental health services, and services related to primary care. Several authors (7-11) have discussed the use of document analysis for qualitative verification with a specific purpose. In this study we used steps (6), namely:

1. Determination and organization of material (based on reading, using criteria for content analysis);

For development of this step, we developed successive readings and systematic ways of seeking to recognize the articulations of CAPS with the primary care service and the community of each service studied. Then we highlighted the paragraphs in the document that described some action (performed, recommended or instituted as a goal) that met the objectives of the study. Thereafter, we organized a spreadsheet containing all TSPs, analyzed based on each proposed objective, in which we entered transcripts with relevant paragraphs, just as they were presented in the document.

Table 1. Example of spreadsheet organization of documentary evidence

Therapeutic Projects	Goals and actions contained in TSPs that aim to articulate the CAPS network of primary health
PT 1	- Supervise and train primary health care teams;
PT 2	- Home visits undertaken by CAPS staff service, supported by the PSF
PT 3	- Not referred

The information organized in this way facilitated the reading of data, making it possible to better visualize the actions.

2. Critical analysis of the document (comments, reports, waiver of recurring issues, coding, interpretation and inferences). As for implementing this second stage of critical analysis of the document, we proceeded to review the 23 TSPs, raising recurrent issues, and coding in terms of the objectives of the study, with the interpretation being made in consideration of the proposed theme: articulation of CAPS with the basic health care services.

After systematically organizing this information, these were grouped, discussed and compared with existing literature.

RESULTS

Looking at the forms of articulation between the ordered network system of mental health care, with a product strategy for the consolidation of the network (ESF), becomes important when they commit to a process that seeks to develop or return the exercise of citizenship to the individuals with mental disorders, providing mechanisms of empowerment for these subjects.

After analyzing the TSPs of the CAPS, we assumed that this was a formative element and ordering of the work process of services, considered essential for CAPS registry at the Ministry of Health, and perceived with professional responsibility as a guiding philosophy of all institutional work. In the primary analysis, we observed that the TSPs met the requirements of the Ministry of Health and that the guiding principles of the psychiatric reform, although, they are at different points in operationalization of activities, and are translated through a disciplinary bias.

Most information referred to the statement of the Ministry of Health concerning the policy that the CAPS, as strategic devices in the ordering of the network, must provide supervision and training of primary care teams, as can be seen in the excerpts of the documents submitted below.

Table 2. Actions envisaged in the 23 TSPs aimed at articulating the CAPS network of primary health care in municipalities in Southern Brazil.

Therapeutic projects	Goals and actions contained in TSPs that aim to articulate the CAPS network of primary health
PT 1	- Supervise and train primary care teams
PT 9	- Nursing must provide support to USF in situations of mental health care.
PT 10	- Ongoing technical training – internal & external – of professionals and technicians who work in psychosocial care and the primary health care network (consultancies, liaison and discussion of clinical cases). - Conducting training for network professionals, study groups, institution-based training for external technicians and professionals.
PT 12	- Supervise and enable primary care teams, services and mental health programs within the territory. - Establishment and organization of matrix teams of mental health staff in primary care.
PT 17	- Create spaces such as courses, supervision, advisory services and visits to other services.
PT 18	- Provide support and supervise the mental health care in the primary health care network of the municipality.
PT 19	- Supervise and enable primary care teams; - Create in each post actions of support matrices with minimum mental health teams.
PT 22	- Supervise and enable primary health teams in mental health programs.
PT 23	- Create spaces such as courses, supervision, advisory services and visits to other services.
PT 3, PT 4, PT 5, PT 7, PT 8, PT 11, PT 14, PT 15, PT 16, PT 20 e PT 21 do not refer to information on the articulation of the CAPS network of primary care services.	

Another ability to communicate as possible and perceivable between the various bodies under study is based on the referral system and counter-referrals as shown in the figures in Table 3 below:

Table 3. Referral and counter-referral of CAPS with primary health in municipalities of the Southern Region of Brazil.

TSPs	Referral and counter-referral of CAPS with primary health
PT 1	- Patient referred by the PSF team
PT 2	- Establish baseline and counter-referral treatment with hospitals and other health services, such as, for example, PACS and PSF.
PT 6	- (See in the health worker a possibility of linking primary care and mental health service).
PT 9	- In cases of scheduling return visits more than three months out, the USF will receive counter-referral of the CAPS and will be responsible for regular monitoring of the user and family; - In cases of stability of the psychiatric condition, the user will be directed to USF for the maintenance phase of treatment, according to information contained in the Transfer of Care Document. With this, the ESF will be responsible for the provision of prescriptions and will provide clinical care for psychiatric reevaluation as indicated, unless there are changes under treatment.
PT 13	- Whenever possible we make referrals to the public network, especially PSF, maintaining returns of more sporadic assessments with us.
PT 18	- Organize a network of hierarchical public assistance, regionalized and decentralized, that is established around the core network to provide a system of referral and counter-referrals with a form of referrals and information flow between the various units.
PT 19	- From the moment the patient is able to return to the community, he will be referred to PSF for monitoring, under the guidance of CAPS.
PT 3, PT 4, PT 5, PT 7, PT 8, PT 11, PT 14, PT 15, PT 16, PT 20 e PT 21	do not refer to information on the articulation of the CAPS network of primary care services.

DISCUSSION

In the process of the Brazilian Psychiatric Reform, the network assistance in the territorial services is a landmark in the reversal from the logic of hospital-centric care. Thus, the current reorganization of the model of mental health care within the SUS envisions CAPS as a strategic device for articulating progressive deinstitutionalization of mental patients⁽¹²⁾.

In the Family Health Strategy (FHS), in turn, the device acts as an important component of the mental health network, being seen as a privileged place for the construction of a new logic of care related to mental disorders⁽¹³⁾. The integration of these two devices is perceived collaboratively in mental health care, through the joint monitoring of the detected problem⁽¹⁴⁾.

In a first analysis, it was revealed that the organization of network activities in mental health, related to the actions of mental health services with primary health care, appears more like principles of the model than an explicit detail of how they occur in practice. Suggested

movements are not sufficient to generate links between the various departments of the care network. A gradual construction of a more articulated guideline of actions would be more appropriate to meet the complexity of demands of those who suffer and seek help in the two services.

Supervision and training of the teams are included in this study as a way to empower professionals to be able to intervene in health problems of the population of a given territory, and to intervene with those who work with mental health issues and mental illness, so they can be valued and cared for in this process, providing greater awareness, creativity and knowledge of the work they are proposing to develop.

Empowering goes beyond the construction of the subject of a critical awareness of the natural, social, cultural and political context of life or the simple capacity to act for improving levels of health, but involves the acquisition of power - that is, it presupposes the experience of an articulated process that integrates the construction of a critical consciousness with the action or the development of the real capacity of intervention and transformation of reality⁽¹⁵⁾.

Thus, when analyzing the data of Table 2, we see different alternatives of empowerment and caring used by professionals as “*Ongoing technical training – internal & external – of professionals and technicians who work in psycho-social care and the primary health care network (consultancies, liaison and discussion of clinical cases). Conducting training for network professionals, study groups, institution-based training for external technicians and professionals.*” (PT 10), “*create spaces such as courses, supervision, advisory services and visits to other services*” (PT 17) and “*create spaces such as courses, supervision, advisory services and visits to other services*” (PT 23).

These concerns are in line with several studies⁽¹⁶⁻²³⁾, which presented different updated strategies for building a mental health care network, and may involve the implementation of mental health interventions in primary care, such as the construction of the matrix of support, a supervision of cases, joint service sets (conducted between specialized and primary care services), and creation of mobile teams.

The results of the study conducted in the city of São Paulo-SP (the *Qualis Project*)⁽²³⁾ displayed an attempt at embodiment, training and intervention of the family health teams, developed for a mental health team motivated by a profound awareness of that field of action, and its specificities and necessities. The author indicated that this experience should promote responsible autonomy and not strengthen the bonds of dependency.

Proposals for actions found in the analyzed documents, such as continuous technical training, consultancy, liaisons and discussion of clinical cases, courses, supervision, advisory services and visits, constitute the

logic of what we mean by matrix support. Specifically, you get the presence of matrix support in passages such as: “*Establishment and organization of matrix teams of mental health staff in primary care*” (PT 12) and “*Create in each post actions of support matrices with minimum mental health teams*” (PT 19). We observed that this information appeared as proposals for establishment or creation of matrix teams of primary care or, at least, reminded us of the idea of the absence of concrete experiences of matrix support.

Therefore, matrix support between teams can be understood as a working methodology that aims to secure specialized back-up care both at the technical and pedagogical levels. This presupposes a shared construction of the referral team (primary care team) and supporters, teams of specialists with the mission of adding knowledge for the referral team, contributing to interventions that increase its capacity to resolve problems⁽²⁴⁾. The matrix aims to provide technical support to the teams, as well as to establish co-responsibility⁽¹⁶⁾. Thus, the role of specialized service would not hold CAPS harmless from this demand, but enables it to act from another perspective, to decentralize care, taking it closer to the user who is the main beneficiary.

A cross sectional study conducted in Bolivia aimed to identify elements to improve response in the face of identified mental health disorders. The authors stressed the need for an adequate education and training of employees in basic care within primary health care⁽²⁵⁾.

As previously demonstrated in the CAPSUL Research Report⁽⁶⁾, the presence of two distinct models for referral of the user was revealed clearly in some TSPs: a typical triangular model, predominant in the current health system, and TSPs identified with an emphasis on hierarchy; and, a model that tends toward greater flexibility in the hierarchy with the benefit of a closer relationship that addresses the logic of the circle, while maintaining some kind of dialogue (back and forth) within the system (e.g., PT 6, PT 13, PT 19). In many excerpts of the TSPs, we also identified the presence of both the triangular model and the circular model (PT 9).

There is still a vision, predominantly fragmented, of work in health services, based on specialized knowledge which provides the strengthening of the logic of referral, such as those found in the following sections: “In cases of scheduling return visits more than three months out, the USF will receive counter-referral of the CAPS and will be responsible for regular monitoring of the user and family”, “[...] the ESF will be responsible for the provision of prescriptions and will provide clinical care for psychiatric reevaluation as indicated, unless there are changes under treatment.” (PT 9).

The logic of referrals, many times, is masked in the system of referral and counter-referral, generating what some authors call “a departure point” (26). According to the authors, this logic tends toward destruction of the bond and lack of responsibility, which is expressed in the passage: “*will be responsible for regular monitoring of the user and family*” and “*the ESF will be responsible for the provision of prescriptions and will provide clinical care*” (PT 9). We realize these observations transfer responsibility, in lieu of sharing it.

We noticed that in other passages, in contrast with the above information, services are concerned with maintaining the responsibility for the care of the user even after discharge to another level of care, “*maintaining returns of more sporadic assessments with us*” (PT 13), and, “*From the moment the patient is able to return to the community, he will be referred to PSF for monitoring, under the guidance of CAPS*” (PT 19).

In the data from Table 3, “*Organize a network of hierarchical public assistance, regionalized and decentralized, that is established around the core network to provide a system of referral and counter-referral with a form of referrals and information flow between the various units*” (PT 18) we realized that we still encountered a crystallized model grounded in fragmentation and bureaucracy, in the forms of relationship between health services, instituting ways of conceiving and intervening in health facilities, reflecting, in this way, a lack of responsibility rather than co-responsibility between professionals and services⁽¹⁶⁾. For other authors⁽²⁴⁾, the logic of hierarchy presupposes a difference in power/knowledge between those who direct and who receive, and a further transfer of responsibility.

Therefore, we agree⁽²⁷⁾ that considering the referral of users of specialized services for primary care and the training process are insufficient to effect a decentralization process, in view of the fragmentary nature of the first, and timeliness of the second⁽²⁸⁾. In this sense, the development of intersectoral actions arises as a form of co-responsibility between the team and the population served.

In a broader analysis, as already demonstrated in another study⁽²⁹⁾, we find that in the TSPs, in many instances, the very idea of the network articulation is much more indicative or programmatic than it is operational, and those items of referral and counter-referral in many situations are empty descriptions (PT 3, PT 4, PT 5, PT 7, PT 8, PT 11, PT 14, PT 15, PT 16) or only indicate the construction of a form of referral and counter-referral (PT 20 and PT 21).

FINAL CONSIDERATIONS

Through this analysis it was observed that there are some services requiring a closer look, open to the ques-

tion of integrated care to the individual, i.e., equipped for psychosocial care that is committed to their customer's attention. Unfortunately, we perceived that the TSPs, many times, can be summed up as an aggregate of material relating to the various professionals that compose the service, presenting a discourse that is not consonant with proposed reformulation of care, and is in some way, individualistic, authoritarian and hierarchical.

In this moment of transition of mental health care, work directed to evaluation of these services becomes indispensable in order to obtain data proving their effectiveness, limitations, and to propose alternatives for improving the dispensed attention. Thus, it is very important to invest in this segment, as acting within the territory, with social, relational and emotional interactions of users and perceived as a fundamental tool for the consolidation of the principles of deinstitutionalization. In fact, the intervention needs to reach beyond real and

imaginary endeavors, where the norm and exclusion are disseminated through the realm of politics, law, legislation, labor and culture.

In summary, we believe that the organization of mental health network activities related to the linkages of mental health services with primary health care appears more like principles of the model, than like an explicit detail of how they occur in practice. Suggested movements are not sufficient to generate links between the various departments of the care network. A gradual construction of an articulated guideline would be more appropriate to meet the complex demands of those who suffer and seek help in these two services.

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